

SECTION I: IDENTIFICATION

13. DSM-IV Current Diagnoses:

Axis I: Primary _____ Secondary _____

Axis II: Primary _____ Secondary _____

Axis III: Related Condition _____

1. Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Unknown

2. Education:

☐ Less than high school ☐ Some high school ☐ High school graduate
☐ Some college ☐ College graduate ☐ Special education
☐ Unknown

3. Academic skills (check the box which best describes the resident's functional achievements):

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can read/recognize simple words
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can read/recognize 3-4 word sentences
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can read at newspaper level (approx. grade 6)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can perform simple addition/subtraction
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Can perform simple multiplication/division

4. Last full-time employment/day program position held: _____

Name: _____

SECTION II: PSYCHOSOCIAL (Continued)

5. Reasons for admission (*check all that apply*):

- | | | |
|--|--|---|
| <input type="checkbox"/> Cannot manage house | <input type="checkbox"/> Fear for personal safety | <input type="checkbox"/> Isolation |
| <input type="checkbox"/> Convalescent care < 30 days | <input type="checkbox"/> Financial problems | <input type="checkbox"/> No primary caregiver |
| <input type="checkbox"/> Decline in ADLs | <input type="checkbox"/> Illness/disease | |
| <input type="checkbox"/> Emergency placement | <input type="checkbox"/> Other (<i>specify</i>): | |

6. Is this person able to evacuate a building in 3 minutes unassisted? ☐ No ☐ Yes _____

7. Provide history to substantiate MR/RC diagnosis:

8. Provide history to substantiate MI diagnosis:

9. Are there current and ongoing family supports? ☐ No ☐ Yes

Please describe: _____

SECTION III: LEVEL OF FUNCTIONING

1. **Basic Functional skills:** Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent

- () Transferring () Bladder () Bowel () Prepares for bed
 () Toileting () Self medication () Eating () Dressing/undressing
 () Bathing () Personal hygiene () Brushing () Selecting appropriate clothes

2. **Advanced Functional skills:** Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent

- () Housework () Use of telephone () Use of Money () Goes outdoors safely
 () Care of clothing () Use of transportation () Manage finances () Treat minor ailments
 () Meal preparation () Shopping () Use of leisure time () Monitor health status
 () Employment () Understands time () Respond to emergencies () Attend medical appts.

Name: _____

SECTION III: LEVEL OF FUNCTIONING: (Continued)

3. **Cognitive skills:** Coding 1= Independent 2=Verbal assistance 3=Physical assistance 4= Dependent

- () Prepares for daily activities () Understands 1 step instructions () Stays on task
 () Arranges for transport () Understands multi-step instructions () Completes assignments
 () Expresses needs and wants () Learns new skills () Transfers skills

4. **Sleep Pattern** (mark one):

- ☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep ☐ Severely disturbed pattern

5. **Ambulation:** (check as needed to describe resident's ability to ambulate)

- ☐ Fully independent ☐ Unsteady ☐ Aids (cane/walker/assis.by 1) ☐ Wheelchair/indep.
☐ Wheelchair/assisted ☐ Chairfast or Posey support ☐ Bedfast ☐ Other (specify): _____

6. **Assistive Devices:** Describe the extent to which corrective/assistive/prosthetic/mechanical devices are used and/or could improve the individual's functional capabilities:

SECTION IV: MEDICAL HISTORY

1. **Psychotropic Medication**

Record any psychotropic medications that have been prescribed and note any changes in dosage in the last three months.

Drugs Code/Name	Purpose	Dosage	Freq	Change	Response to Rx

2. STAT/PRN Administration of Medication

In the last 60 days, has the individual received an emergency (STAT) or PRN administration of medication to control her/his behavior?

☐ No ☐ Yes

If "yes," please indicate the medication that was administered and the behavior for which the medication was administered:

3. Physician Review

Is a physical examination completed and signed by a licensed physician in the last 12 months attached?

- ☐ Yes, skip, physical examination supplement.
☐ No, the physical examination supplement must be completed and signed by a licensed physician.

4. Comments:

5. QMRP Signature _____ **Telephone:** (____) _____ **Date:** _____

Name: _____

SECTION V: BEHAVIORAL AND PSYCHIATRIC ASSESSMENT

1. Affective Behavior Observations

a. Physical Features (*mark all that apply*):

- | | | |
|--|--|---|
| <input type="checkbox"/> Clean/Tidy | <input type="checkbox"/> Poor hygiene/Unwashed | <input type="checkbox"/> Well-groomed |
| <input type="checkbox"/> Careless/Dishevelled/Sloppy | <input type="checkbox"/> Normal street dress | <input type="checkbox"/> Wearing bedclothes |
| <input type="checkbox"/> Makeup or jewelry | <input type="checkbox"/> No apparent effort at personal appearance | |
| <input type="checkbox"/> Non-seasonal clothing | <input type="checkbox"/> Other (<i>specify</i>): _____ | |

b. Level of Consciousness (*mark all that apply*):

- ☐ Alert ☐ Drowsy ☐ Attentive ☐ Inattentive ☐ Lethargic ☐ Other (*specify*): _____

c. Manner (*mark all that apply*):

- | | | | | | |
|--|------------------------------------|---|--|--|--------------------------|
| <input type="checkbox"/> Warm | <input type="checkbox"/> Shy | <input type="checkbox"/> Threatening | <input type="checkbox"/> Concerned about others | <input type="checkbox"/> Outgoing nature | <input type="checkbox"/> |
| Silly <input type="checkbox"/> Sincere | <input type="checkbox"/> Apathetic | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Sense of humor | <input type="checkbox"/> Suspicious | |
| <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Childlike | <input type="checkbox"/> Reluctant to Respond | <input type="checkbox"/> Other (<i>specify</i>): _____ | | |

d. Mood and Affect (*mark all that apply*):

- | | | | |
|--|-------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Appropriate in quality and intensity to stated themes | | | |
| <input type="checkbox"/> Flat or blunted | | | |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Anxious, fearful or worried | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Angry, belligerent or hostile | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Delusional | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Homicidal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Other (<i>specify</i>): _____ | | | |

e. Form of Thought (*check all that apply*):

- | | | | |
|-----------------------------------|---|--|--|
| <input type="checkbox"/> Coherent | <input type="checkbox"/> Incoherent/Illogical | <input type="checkbox"/> Blocking | <input type="checkbox"/> Tangentiality |
| <input type="checkbox"/> Relevant | <input type="checkbox"/> Irrelevant/Rambling | <input type="checkbox"/> Impoverished | <input type="checkbox"/> Circumstantiality |
| <input type="checkbox"/> Logical | <input type="checkbox"/> Loose Associations | <input type="checkbox"/> Perseveration | <input type="checkbox"/> Pressured |

f. Orientation Level (*mark one*):

- | | | |
|--|--|---|
| <input type="checkbox"/> Oriented X3; clear at all times | <input type="checkbox"/> Oriented X3; forgetful at times | <input type="checkbox"/> Oriented to person and place |
| <input type="checkbox"/> Oriented to person | <input type="checkbox"/> Oriented to situation | <input type="checkbox"/> Oriented to bathroom/bed |
| <input type="checkbox"/> Confused at times in day | <input type="checkbox"/> Confused at times at night | <input type="checkbox"/> Disoriented X3 |
| <input type="checkbox"/> Nonresponsive | <input type="checkbox"/> Unable to determine | |

g. Communication Ability (*check all that apply*):

- | | | | | |
|--|---|--------------------------------------|---|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Reads | <input type="checkbox"/> Writes | <input type="checkbox"/> Speech unclear/slurred | <input type="checkbox"/> Gestures/aids |
| <input type="checkbox"/> Inappropriate content | <input type="checkbox"/> Stammer/stutter/impediment | <input type="checkbox"/> Eye contact | <input type="checkbox"/> Unresponsive | |

h. Socialization (*mark all that apply*):

- ☐ Appropriately responds to others' initiations
- ☐ Appropriately initiates contact with others
- ☐ Inappropriate responses/interactions (*describe*): _____ ☐

Withdrawn

i. Attitude (*mark one*):

- ☐ Cooperative ☐ Oppositional ☐ Agitated ☐ Guarded

Name: _____

SECTION V: BEHAVIORAL AND PSYCHIATRIC ASSESSMENT (Continued)

2. Chart of Behavior

Complete the chart, based on all available information for the last 3 months, including information from the individual's medical records and staff comments:

Frequency		Frequency	
<input type="checkbox"/> Dangerous smoking behavior	_____	<input type="checkbox"/> Destroys property	_____
<input type="checkbox"/> Refuses medications	_____	<input type="checkbox"/> Exposes self	_____
<input type="checkbox"/> Uncooperative diet	_____	<input type="checkbox"/> Is sexually aggressive	_____
<input type="checkbox"/> Uncooperative hygiene	_____	<input type="checkbox"/> Abuses--verbally	_____
<input type="checkbox"/> Refuses activities	_____	<input type="checkbox"/> Threatens--verbally	_____
<input type="checkbox"/> Refuses to eat	_____	<input type="checkbox"/> Threatens--physically	_____
<input type="checkbox"/> Self-induces vomiting	_____	<input type="checkbox"/> Strikes others--provoked	_____
<input type="checkbox"/> Impatient/demanding	_____	<input type="checkbox"/> Strikes others--unprovoked	_____
<input type="checkbox"/> Frequent/continuous yelling	_____	<input type="checkbox"/> Talk of suicide	_____
<input type="checkbox"/> Wanders	_____	<input type="checkbox"/> Suicidal threats	_____
<input type="checkbox"/> Tries to escape	_____	<input type="checkbox"/> Suicidal attempts	_____
<input type="checkbox"/> Seclusiveness	_____	<input type="checkbox"/> Injures self	_____
<input type="checkbox"/> Suspicious of others	_____	<input type="checkbox"/> Other (specify):	_____
<input type="checkbox"/> Lies purposefully	_____	<input type="checkbox"/> Other (specify):	_____
<input type="checkbox"/> Steals deliberately	_____	<input type="checkbox"/> None	_____

3. Placement in Seclusion/Physical Restraints/Behavior Change(s)

In the last 60 days, has the individual been placed in seclusion or other physical restraints to control dangerous behavior?

☐ No ☐ Yes

If "yes," describe the behavior and type of restraints: _____

Comments:

Name: _____

SECTION V: BEHAVIORAL AND PSYCHIATRIC ASSESSMENT (Continued)

4. Functional Assessment Summary (ICAP, ABS, etc.)

Describe current functional status - improvement and/or decline. Identify any strengths or weaknesses which may impact the individual's participation in specialized services.

- a. Motor Skills (This domain assesses one's sensory and motor abilities. Visual and auditory abilities are examined, as are fine-motor and gross motor skills.)

- b. Social & Communication Skills (This domain assesses receptive and expressive abilities and how one utilizes those skills to make needs and requests known. This area also assesses the individual's ability to interact with others.)

- c. Personal Living (This domain pertains to eating, toileting, maintaining a clean, neat appearance, taking care of clothing, dressing and undressing, etc.)

- d. Community Living (This area addresses skills relating to handling money, telling time, acting responsibility, preparing meals, doing laundry, etc.)

- e. Broad Independence (This area addresses the individual's overall ability to take care of him/herself and interact in his environment.)

- f. Problem Behaviors (Describe any behaviors which are disconcerting or upsetting to others, such as inappropriate physical contact, stereotypical or being overly active. Included in this domain may be behaviors that relate to sexual activity in socially unacceptable ways and behaviors that cause harm to oneself. Describe any behavior strategies that have been implemented and their impact on the behavior.)

SECTION VI: DUAL DETERMINATION RECOMMENDATION

2. SSN: _____ 3. Medicaid #: _____

☐ No

☐ Yes, check at least one of the following and substantiate by completing item 5 (include copy of assessment)

☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Administered by: _____ Title: _____

<input type="checkbox"/> Autism	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Blindness	<input type="checkbox"/> Hemiparesis	<input type="checkbox"/> Paraparesis
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hemiplegia	<input type="checkbox"/> Paraplegia
<input type="checkbox"/> Deafness	<input type="checkbox"/> Hydrocephaly	<input type="checkbox"/> Polio
<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Quadriplegia
<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Microcephaly	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Friedreich's Ataxia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Cord Injury
<input type="checkbox"/> Other; specify: _____		

	Independent	Minimal	Moderate	Unable
a. Takes care of most personal needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Understands most simple commands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Communicates basic needs and wants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Is employed at a productive wage w/o long term supervision/support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Learns new skills w/o aggressive and consistent training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Generalizes trained skills to other environments w/o aggressive and consistent training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Demonstrates behaviors appropriate to time, situation, and place w/o supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION VI: DETERMINATION RECOMMENDATION (Continued)**8. SPECIALIZED SERVICES RECOMMENDATION - MR/RC**Does resident require specialized services? ☐ No ☐ Yes

(Mark all that apply):

CURRENT SPECIALIZED SERVICES**RECOMMENDATIONS**

Continue Discontinue New

<input type="checkbox"/> 1. Behavior Skills	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 2. Communication	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 3. Community Living Skills	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 4. Resource Utilization Skills	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 5. Day Health and Habilitation	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 6. Education	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 7. Environmental Skills	7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 8. Pre-Vocational/Sheltered Employment	8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 9. Self-Advocacy	9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 10. Self-Help/Personal Care	10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 11. Social Skills Development	11.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 12. Supported Employment	12.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 13. Task Learning	13.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 14. Transportation to Specialized Services	14.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 15. Assistive Technology Evaluation	15.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 16. Assistive Technology	16.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 16a. Communication devices	16a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 16b. Compensatory devices	16b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 16c. Environmental control devices	16c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 16d. Environmental modifications	16d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 16e. Feeding devices	16e.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 16f. Wheelchair Seating/positioning	16f.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 16g. Wheelchair fitting-customized	16g.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 16h. Mobility aids	16h.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 17. Other adaptive devices (specify): _____	17.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rationale: _____

9. SERVICES OF LESSER INTENSITY - MR/RC

Does resident require services of lesser intensity?

☐ NO ☐ YES

(Mark all that apply)

- ☐ 1. Adjustment needs
- ☐ 2. Basic grooming
- ☐ 3. Behavior management
- ☐ 4. Non-customized durable medical equipment
- ☐ 5. Occupational therapy
- ☐ 6. Physical therapy
- ☐ 7. Restorative nursing
- ☐ 8. Speech-language pathology
- ☐ 9. Sensory stimulation
- ☐ 10. Visual/Hearing
- ☐ 11. Other _____

Print Assessor's Name _____ Title _____ Telephone (____) _____

Assessor/QMRP Signature _____ Date: _____

Name: _____

SECTION VI: DETERMINATION RECOMMENDATION (Continued)

10. As substantiated by your evaluation, does the individual meet the DSM-IV criteria for dementia or a related disorder in the absence of a **primary major mental illness**?

☐ No, continue

☐ Yes, substantiate below, stop here and sign on page 10

Rationale: _____

11. As a result of a major mental disorder, the individual has functional limitations in the following areas: (Mark all that apply):

a. Interpersonal functioning

- ☐ 1. Difficulty interacting appropriately/communicating effectively with other persons
- ☐ 2. A history of altercations, evictions, firing, fear of strangers
- ☐ 3. Avoids interpersonal relationships
- ☐ 4. Is socially isolated
- ☐ 5. Other (specify): _____
- ☐ 6. None

b. Concentration, persistence and pace

- ☐ 1. Difficulty in sustaining focused attention to complete work tasks
- ☐ 2. Difficulty in sustaining focused attention to complete home tasks
- ☐ 3. Inability to complete tasks within established time period
- ☐ 4. Makes frequent errors or requires assistance in the completion of tasks
- ☐ 5. Other (specify): _____
- ☐ 6. None

c. Adaptation to change

- ☐ 1. Difficulty in adapting to typical changes associated with work, school or family
- ☐ 2. Manifests agitation, exacerbated signs and symptoms associated with the illness
- ☐ 3. Withdraws from the situation
- ☐ 4. Requires intervention by MH or judicial systems
- ☐ 5. Other (specify): _____
- ☐ 6. None

12. As a result of a major disorder, the individual has required treatment within the last two years for:

- ☐ Psychiatric treatment more intensive than outpatient care
- ☐ Episodes of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials
- ☐ None, continue to item 13

13. Does the individual meet the DSM-IV criteria for a serious mental illness?

☐ No

☐ Yes, check at least one of the following and substantiate below (P=primary S=secondary)

- | P | S |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

- | P | S |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Rationale: _____